Workers' Compensation Premium Indication Request

MERCER

FOR MEMBERS OF THE CMA/COUNTY MEDICAL ASSOCIATIONS AND SOCIETIES 101656w

For more information complete the form below and fax to Mercer at: **515-365-0681,** or scan and e-mail to: **LH.Admin@mercer.com**

Member Information

Member Name:_____ County Medical Association/Society:_____

Practice Name:_____

Address:_____

City:_____ State: CA Zip:_____

Phone: (_____)_____ Fax: (_____)_____

e-mail Address:_____ Contact:_____

Years in Business:_____ Years of Experience:_____ Tax ID/FEIN Number:_____

Workers' Compensation *For information and a premium indication, please include the following:*

Present Workers' Compensation Carrier:_____

Current Rate (Per $100):_____ Policy Renewal Date:_____

Number of claims in the last 4 years:_____ Have you had a lapse in coverage in the past 3 years?..... ☐ Yes ..... ☐ No

Number of Employees: Full time_____ Part Time_____ Annual Employee Payroll: $_____

Are there any officers/partners included in the annual payroll above?..... ☐ Yes ..... ☐ No
If yes, to be excluded?..... ☐ Yes..... ☐ No..... If yes, exclude from above payroll: $_____

If incorporated, do you wish coverage for yourself? ☐ Yes ☐ No **NOTE: All officers who do not own stock must be covered.**

Signature

I authorize Mercer to obtain a Workers' Compensation insurance premium indication(s) on my behalf:

Signature:_____ Date:_____

Sponsored by: CALIFORNIA MEDICAL ASSOCIATION

Underwritten by: PREFERRED EMPLOYERS Insurance | a Berkley Company

Administered by: MERCER

